

## Part II. Health care choices directive

If you named a durable power of attorney for health care, but do not want to complete a health care choices directive, initial here, then go to **Part III**.

I, \_\_\_\_\_, Social Security No. \_\_\_\_\_,

want those involved in my health care to understand my wishes in the event I cannot communicate or make decisions on my own. I make this directive to provide clear and convincing proof of my wishes and instructions about my health care and treatment. In the event my doctor believes medical treatment will lead to my recovery, I want to have the treatment. I also want to have care and treatment for pain or discomfort even if this treatment might shorten my life, affect my appetite, slow down my breathing or be habit-forming.

**If I have a terminal illness or condition and there is no reasonable hope I will recover, or if I am persistently unconscious, I direct all of the life-prolonging procedures I have initialed below to be withheld or withdrawn.**

### I direct the following treatments to be withheld or withdrawn:

- ☐ Surgery or other invasive procedures
- ☐ Cardiopulmonary resuscitation (CPR) to restart my heart or breathing
- ☐ Antibiotics
- ☐ Dialysis
- ☐ Mechanical ventilator (respirator)
- ☐ Artificially supplied nutrition and hydration (including tube feeding)
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ All other “life-prolonging” medical treatments or surgeries that are merely intended to keep me alive without reasonable hope of making me better or curing my illness or injury.

I direct the donation of my organs or tissues. I realize my body may need to be maintained artificially after my death until my organs can be removed.

☐ Yes    ☐ No    ☐ I do not want to address this question now.

**Part II. Health care choices directive (continued)**

I also give the following directions regarding my health care:

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**Optional:**

Describe what you consider an acceptable quality of life. For example, being able to recognize my loved ones, make decisions, communicate, feed yourself, etc.

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Attach extra pages if necessary. Sign and date the attached pages.

Make sure to talk about this directive and your wishes with your agent, your doctors, family, friends and clergy. Give each of them a copy of the directive. Bring a copy with you when you go to a hospital or other health care facility. Keep the original with your important papers.

Signature \_\_\_\_\_ Social Security No. \_\_\_\_\_